TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Orthropaedic Surgical

Respondent Name
East TX Educational INS Assn

MFDR Tracking Number
M4-13-3293-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We followed the proper protocol in this patients care by obtaining authorization. We are asking that you reprocess our claim for payment."

Amount in Dispute: $82.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We feel our denial of CPT 97012 was correct since this code was not preauthorized as an approved procedure."

Response Submitted by: Claims Administrative Services, Inc., 501 Shelley Drive, Tyler, Texas 75701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6 – April 1, 2013	97012 –GP	$82.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduce for absence of precertification/authorization
   - 721 – Per Rule 134.600 of the Texas Administrative Code this procedure requires preauthorization. Preauthorization not obtained
   - 930 – Preauthorization required. Reimbursement denied

- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is related to physical therapy services. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduce for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p) states,

   > Non-emergency health care requiring preauthorization includes:
   >
   > (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   >
   > (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   >
   > (i) Modalities, both supervised and constant attendance;

   Review of the submitted information finds:

   - Partial authorization dated 3-1-2013 from Review Med
   - Excluded codes, 97035, 97032, 97012

   The insurance carrier's denial reason is supported as insufficient information was found to support the disputed service were prior authorized. Therefore, additional reimbursement cannot be recommended.

2. The Division finds pursuant to requirements of Rule 134.600(p)(5) reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.